DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No.0938-0313

INSTRUCTIONS FOR COMPLETING HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

STATEMENT CONCERNING INFORMATION COLLECTION REQUIREMENTS AND USES

This form is required to obtain or retain Medicare benefits. It serves two purposes. First, it provides basic information about the Hospice which is necessary for the State to properly schedule a survey. Second, it provides a data-base necessary for responding to questions frequently asked by Congress, Federal agencies, and interested members of the public.

Submission of this form will initiate the process of obtaining a decision as to whether the Conditions are met.

Answer all questions as of the current date. Return the original and first two copies to the State Agency; retain the last copy for your files. If a return envelope is not provided, the name and address of the State Agency may be obtained from the nearest Social Security Office.

Detailed instructions are given for questions other than those considered self-explanatory.

Item I

- Request to establish eligibility in - current Hospice Benefits are available only through the Medicare program.
- Medicare provider number - insert the facility's six digit Medicare Provider Number. Leave blank on initial requests for certification.
- State/County and State/Region Codes - Leave blank. The Centers for Medicare & Medicaid Services Regional Office will complete.
- Related provider number - If Hospice is affiliated with any other type Medicare provider, insert the related facility's six digit Medicare Provider Number.

Item IV - If a service is provided directly by the facility place a “1” the appropriate block. If a service is provided through an outside source (i.e., by contract/arrangement), place a "2" in the appropriate block.

HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

(Read Instructions and Information Collection Statement On Cover Sheet of Form Prior to Completion)

I. Identifying Information

Name of Hospice

Street Address

Request to Establish Eligibility In
1. ____ Medicare
PH1

City, County and State

Zip Code

Medicare/Provider Number
PH2

State/County
PH3

State/Region
PH4

Telephone Number
(include area code)
PH5

Related Provider Number
PH6

II. Type of Hospice *(Check One)*
PH7

1. ☐ Hospital
2. ☐ Skilled Nursing Facility
3. ☐ Intermediate Care Facility
4. ☐ Home Health Agency
5. ☐ Freestanding Hospice

For Hospitals Only *(Check One)*
A. ☐ JCAH Accredited
B. ☐ AOA Accredited
C. ☐ Both JCAH and AOA Accredited
D. ☐ Non-Accredited

Fiscal Year Ending Date

III. Type of Control *(Check One)*
PH8

Non-Profit
1. ☐ Church
2. ☐ Private
3. ☐ Other

Proprietary
4. ☐ Individual
5. ☐ Partnership
6. ☐ Corporation
7. ☐ Other

Government
8. ☐ State
9. ☐ County
10. ☐ City
11. ☐ City-County

12. ☐ Combination Government and Nonprofit
13. ☐ Other

IV. Services Provided:
By staff, place a "1" in the block(s)
If under arrangement, place a "2" in the block(s)
PH9

Core:
1. ☐ Physician Services
2. ☐ Nursing Services
3. ☐ Medical Social Services
4. ☐ Counseling Services

5. ☐ Physical Therapy
6. ☐ Occupational Therapy
7. ☐ Speech-Language Pathology
8. ☐ Home Health Aide
9. ☐ Homemaker
10. ☐ Medical Supplies
11. ☐ Short Term Inpatient Care — PH1O — A. _____Acute — B. _____Respite
12. ☐ Other(Specify)

Name and Address of Contractee

Medicare Provider/Supplier Number

V. Number of Employees/ Volunteers Full-time Equivalent (Top section of professional category reflects total number of FTE (i.e., PH 11 through PH 18))

Physicians PH11		Registered Professional Nurses PH12		Licensed Practical Nurses/ Licensed Vocational Nurses PH13		Medical Social Workers PH14		Total Number PH19	
Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.		
Homemakers PH15		**Home Health Aide PH16**		**Counselors PH17**		**Others PH18**		Employees A.	Volunteers B.
Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.		

Whoever knowingly or willfully makes or causes to be made a false statement or representation on this form may be prosecuted under applicable Federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of its agreement or contract with the State agency or the Secretary as appropriate.

Name of Authorized Representative and Title (Typed)	Signature	Date PH20